TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CENTERPOINT MEDICAL CENTER

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-17-2537-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 25, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "When medical services are rendered by an out-of-state medical provider, there is not necessarily a statute or guideline in place clarifying whether payment should be based upon Texas' fee schedule or based upon the payment guidelines of the state in which services were rendered. It's our contention that payment should be made pursuant to Missouri's charge-based prevailing community rate metric and not the Texas fee schedule."

Amount in Dispute: $5,669.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual paid the OPPS amount as required by Rule §134.403."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 26, 2016	Outpatient Hospital Services	$5,669.18	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.1 sets forth general provisions regarding medical reimbursement.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. Texas Labor Code §413.031 entitles health care providers to a review of services if payment is reduced or denied.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - 370 – THIS HOTPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G).
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION

Issues

1. Under what authority is this request for medical fee dispute resolution considered?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Missouri to an injured employee subject to a Texas Workers' Compensation insurance claim. The health care provider has requested medical dispute resolution in accordance with Texas Labor Code Section 413.031(a)(1), which entitles a health care provider to a review of medical services if payment is reduced or denied. Because the requestor has sought the administrative remedy provided in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the division concludes it has jurisdiction to decide the medical fee issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable division rules.
2. The division's *Hospital Facility Fee Guideline—Outpatient*, is applicable to acute care hospitals, defined at 28 Texas Administrative Code §134.403(b)(1) as:

   > a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.

   No information was presented to support the disputed services were performed at a facility appropriately licensed by the Texas Department of State Health Services. Review of information maintained by the Texas Department of State Health Services finds no license for any hospital facility located in Independence, Missouri. The division therefore concludes the requestor is not licensed as an acute care hospital in Texas.

   As there is no division fee guideline that applies to the outpatient hospital facility services in dispute, reimbursement is subject to the general medical payment provisions of 28 Texas Administrative Code §134.1(e), which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in Rule §134.1(f).
3. In the following analysis, the division examines the positions of both parties and the evidence presented to support, or to refute, each party's determination of a fair and reasonable payment amount, in order to establish which party presents the best evidence of an amount that will achieve a fair and reasonable reimbursement for the disputed services. The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence.

   Rule §134.1(f) requires that:

   > Fair and reasonable reimbursement shall:
   > (1) be consistent with the criteria of Labor Code §413.011;
   > (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   > (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

   The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality

medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 *South Western Reporter Third* 643, 656 (Texas 2004). Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "[E]ach . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

Texas Labor Code §413.011(d) requires that:

> Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), effective May 31, 2012, 37 *Texas Register* 3833, requires the requestor to provide:

> documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable

The division first reviews the information presented by the requestor to determine whether it has met the burden to show that the payment amount sought is a fair and reasonable rate of reimbursement for the services in this dispute. If the requestor's evidence is persuasive, then the division will review the respondent's evidence.

Review of the information presented by the requestor finds that:

- The requestor contends "that payment should be made pursuant to Missouri's charge-based prevailing community rate metric and not the Texas fee schedule."
- The requestor did not provide any information to explain or support how such a fee may be calculated.
- The requestor did not explain or provide any documentation to support how such a fee is fair and reasonable for the disputed services.
- The requestor did not explain or provide any documentation to support how the suggested methodology ensures the quality of medical care.
- The requestor did not explain or provide any documentation to support how the suggested methodology controls medical costs.
- The requestor did not present any nationally recognized published studies, division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments (if any such are available) to support the requested reimbursement amount.
- The Division has previously found that charge-based fee calculation methods do not produce an acceptable payment amount. Such methodologies were considered and rejected by the division in the adoption preamble to the division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

  > A discount from billed charges was another method of reimbursement which was considered. . . . this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.

  Consequently, payment amounts calculated using a charge-based metric cannot be favorably considered when no other data or documentation was submitted to support that the payments sought are a fair and reasonable reimbursement for the services in dispute.
- The requestor did not support that the methodology meets the criteria of Texas Labor Code §413.011(d).
- The requestor did not support that the methodology meets the requirements of Rule §134.1.

After reviewing the submitted information, the division concludes the requestor has not met the burden to show that the payment amount requested is a fair and reasonable reimbursement for the services in dispute. Accordingly, no additional payment is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	May 19, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.